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The magazine of the Marin Medical Society

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Change Is in the Air

Irina deFischer, MD

We have much to celebrate this time of year—new officers, new board members, a new magazine editor and, hopefully, a renewed interest in the Marin Medical Society!

The editorial board thanks Steve Osborn, who stepped down in February, for his seven years at the helm, having shepherded us through the transition from bulletin to award-winning magazine. He is now involved in a number of other projects and continues to edit *Sonoma Medicine*.

The new editor of *Marin Medicine*, Howard Daniel, is new not only to our publication, but to the North Bay. Now living in Santa Rosa with his wife Sandra, he moved here, following a 27-year sojourn in Hawaii, to be closer to kids and grandkids, all of whom are on "the mainland," including one, a nurse, in this area. Howard has been writing and editing for most of his life, but he turned it into a career only at age 50, when he was hired as the speechwriter for Hawaii's governor. He then served as publications manager for one of Hawaii's largest corporations and vice president for editorial services at the state's premier public relations firm, where he reviewed and strengthened all written output "before it went out the door." Since arriving in the Bay Area, he has been working as a writing and editing freelancer, Pen-for-Rent.

Dr. deFischer, a family physician at Kaiser Petaluma, is chair of the Marin Medicine *editorial board.*

Born and raised in New Jersey, Howard majored in Russian area studies at Yale, then earned an M.A. in the same field at Harvard before embarking on the first part of his career—in international relations. He began as a Peace Corps volunteer working with farmers in a north-central Indian village, then joined the U.S. Foreign Service, which took him to embassies and consulates in Brazil and the USSR. He reports that his familiarity (now rather rusty) with Russian, Hindi and Portuguese has sharpened his understanding of the English language.

We are looking forward to working with Howard!

There are changes afoot in CMA as well—a move from the traditional annual House of Delegates deliberations to a year-round online format that solicits input from the membership as issues come up.

In light of all our recent accomplishments—the defeat of Proposition 46, the repeal of the SGR, the GPCI fix—it is sobering to see declining membership numbers. Did you know that in Marin County this year only 18% of physicians are dues-paying members of the MMS and CMA? Although only members have access to purchasing discounts as well as legal and practice-management support, all physicians benefit from CMA's legislative advocacy. Why are so few of us willing to pay to keep our organizations going?

This is analogous to the declining rate of immunization among our county's children. The parents of unimmunized children count on herd immunity—other parents immunizing their children—to protect their own children from childhood diseases without exposing them to the imagined risks of vaccines. This works up to a point—until the percentage of immunized children drops below the threshold needed to maintain effective herd immunity.

There is strength in numbers—the MMS and CMA have greater credibility, not to mention resources, when we are seen to represent the majority of practicing physicians from all specialties and modes of practice. It is easy for us to get caught up in the day-to-day demands of patient care, the juggling of work and home life, and to assume our medical groups and/or specialty societies will look out for our best interests. They will do that, up to a point, but in the end we are far more powerful when we join forces. Please renew your membership and encourage your non-member friends and colleagues to join. Together we are stronger! ◇

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Cesarean Section and Long-Term Child Health

Mark Sloan, MD

In 1971, the year I graduated from high school, 6% of American children were born by cesarean section. By 2013 the cesarean rate had risen to 32.7%—a five-fold increase in little more than four decades. As a pediatrician, I witnessed that increase firsthand and, in general, welcomed it. I'd been in enough tense delivery room situations early in my career to see the increase as a positive change. More cesareans meant safer births for more babies, I thought. What could be bad about that?

I witnessed another trend firsthand during those decades: as the 1980s gave way to the 1990s and 2000s, the number of children with chronic inflammatory and autoimmune disorders steadily climbed. More and more of my young patients were diagnosed with asthma. Type 1 diabetes, previously a disease of school-aged children and teenagers, began to strike at younger ages than before—as young as 11 months in one memorable case. And although I didn't see much of it, inflammatory bowel disease was becoming more common across the country.

The rising incidence of inflammatory diseases in younger-than-usual children spurred a search for causative factors in pregnancy and early infancy, when the fetus and newborn are particularly sensitive to environmental insults.

Dr. Sloan, who teaches pediatrics at the Santa Rosa Family Medicine program, serves on the SCMA Editorial Board.

One obvious environmental trend was the increasing cesarean section rate, which roughly paralleled the increase in disease. Scientists began to wonder: could the two somehow be connected?

Concerns about a possible link between cesarean section (CS) and chronic inflammatory diseases in childhood date to the early 1990s, after the Soviet Union disintegrated and previously isolated Eastern European countries opened to travel. As public health researchers fanned out across the old Soviet bloc, they noticed something odd: an "asthma gradient" that ran from east to west, with asthma much more prevalent in industrialized western countries than in the more rural, formerly socialist nations to the east. A child living in Sweden, for example, was significantly more likely to have asthma than a child living in Estonia—only a couple of hundred miles away.[1] A lot of analysis and a little out-of-the-box thinking eventually led to an unorthodox theory.

Researchers noted that while CS rates in Western European countries had risen sharply since the 1970s, those in the countries of the former Soviet bloc had remained low and relatively stable. Variation in national CS rates roughly matched the variation in asthma prevalence.

At about the same time the importance of the newborn gut microbiota to immune system development—and the idea that mode of delivery exerted a strong influence on the composition of the microbiota—were coming under scrutiny. Could the dots be connected? Could at least some of the asthma gradient—and by extension some of the variation in prevalence of other chronic inflammatory diseases—be explained by differences in Cold War birthing practices?

While the issue remains far from settled, current evidence appears to support a link between CS and a mild-to-moderately increased risk of diseases related to immune system malfunction. This article examines three of those diseases: asthma, type 1 diabetes and inflammatory bowel disease.

Asthma

Asthma is by far the most common chronic inflammatory disease of childhood and, with millions of American children afflicted by this disease, a pressing public health issue. As noted above, its prevalence has increased disproportionately in industrialized, more affluent nations compared with poorer and more rural countries. Asthma has been linked to a number of environmental factors, including air pollutants, indoor allergens, dampness and mold. To date, more than 30 research papers have examined a possible cesarean section-asthma (CS-A) link.

Initial studies found a strong association between CS and asthma. In a retrospective birth cohort, for example, Xu (2001) found that Finnish adults with current asthma were three times more likely to have been born by CS than by vaginal delivery (VD).[2] Methodological problems dogged this and other early research: the failure to adjust for prematurity and a history of maternal

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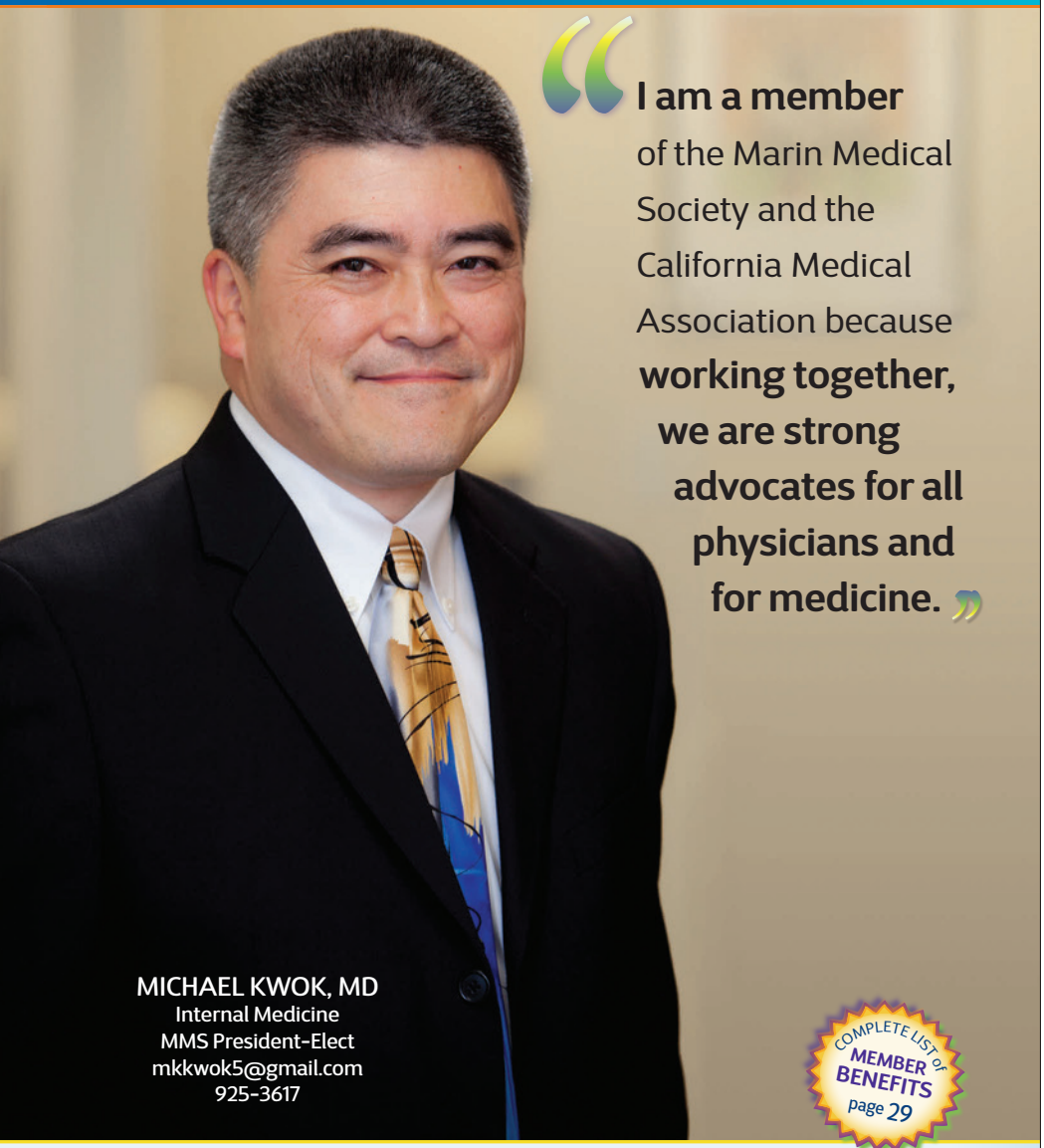
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asthma, known risk factors for both CS and child asthma, significantly clouded interpretations of the data. However, separate meta-analyses by Bager[3] and Thavagnanam[4] in 2008 arrived at similar, if less robust, conclusions: CS was associated with a 20% increase in risk of child asthma.

The majority of studies published since 2010—more statistically rigorous than their predecessors—have found a significant CS-A association. Recent retrospective birth cohort studies in Sweden[5] and Denmark[6]—involving a combined 2.2 million mother-child couplets—found that, similar to the 2008 meta-analyses, CS babies were about 20% more likely to be diagnosed with asthma in childhood than were vaginally born infants.

Problems with CS-A research persist, however. Asthma, particularly in infants and young children, can be difficult to differentiate from viral respiratory infections, a source of confusion that can lead to both over- and under-diagnosis. Diagnostic criteria can differ significantly between studies as well: health questionnaires or parental recall are used by some researchers; hospital admission or pharmacy registries by others.

Virtually all studies on the subject of CS and future child health are retrospective epidemiological studies, and so are more subject to bias and confounding than prospective studies. For example, significant factors like maternal smoking, a family history of asthma, and socioeconomic status may or may not have been accurately recorded in decades-old birth registries.

Finally, while epidemiological studies can show that an association exists, they cannot prove causation. Prospective studies with meticulous record keeping would provide a clearer picture, but the gold standard of medical research—a randomized controlled study allocating women to either cesarean or vaginal birth—is obviously impossible.

Diabetes and IBD

Type 1 diabetes mellitus (T1D) is a progressive autoimmune disorder in

which a T-cell-mediated autoimmune process targets and destroys pancreatic beta cells. The etiology of T1D remains elusive; genetic susceptibility and a number of environmental factors have been implicated.

The number of children living with T1D has increased dramatically in the last quarter century. During the 1990s the global incidence of T1D rose an estimated 2.8% per year.[7] The 2009 EURODIAB study predicted a doubling of new cases in European children between 2005 and 2020.[7] In the United States, the prevalence of T1D increased 21.1% between 2001 and 2009.[8]

The dramatic surge in new cases of T1D suggests that as yet unidentified environmental factors are to blame. The increase has been particularly steep among the very young (<4 years old), a trend that again led researchers to examine the prenatal and perinatal periods for possible answers. In 1992, Dahlquist was the first to demonstrate an association between T1D and CS.[9]

A 2008 meta-analysis of 20 studies demonstrated a 20% increased risk of T1D in CS-born children after adjustment for gestational age, birth weight, maternal diabetes and other potential confounders.[10] Since 2010, research in Canada, Germany and Australia has found similarly increased risks. Support for a CS-T1D association hasn't been universal, however: a recent Swedish study found that the association nearly disappeared when siblings were used as controls.[11] Still, the discussion among many diabetes experts has shifted from whether a CS-T1D association exists to exploring possible mechanisms for that association.

Inflammatory bowel disease (IBD) is a chronic inflammatory disorder consisting of two major phenotypes: Crohn's disease and ulcerative colitis. The etiology of these diseases is multifactorial, involving complex interactions of genes, the immune system, the gut microbiota and environmental factors. As is true for asthma and type 1 diabetes, the incidence and prevalence of IBD have risen significantly in the last 25 years.

Although not as well studied as the CS-A and CS-T1D associations, a half-dozen studies in Europe and Australia since 2009 have consistently demonstrated a mild-to-moderate increase in risk of IBD for CS-born children. A recent Danish national cohort study found the risk, adjusted for a number of possible confounders, to be increased by 29%.[12]

Possible Mechanisms

Hypothetically, if a causal link does exist between CS and at least some cases of chronic immune system disorders, what might be the mechanism(s)? Leading theories include (1) changes in the neonatal gut microbiota induced by CS, (2) inadequate immune system priming due to the absence or shortening of labor, and (3) other factors for which CS may simply be a marker.

Neonatal gut microbiota. The bacteria that colonize the neonatal intestine are known to play a major role in the development of the mammalian immune system. In experiments with germ-free mice, failure to normally colonize the gut at birth leads to severe defects in gut-associated lymphoid tissue, cell-mediated immunity, and antibody production.[13]

CS alters the gut microbiota by allowing bacteria from the skin and hospital environment to colonize the lower intestine, rather than the bacteria normally acquired from the maternal birth canal and perianal area in a vaginal birth. These abnormal bacteria suppress TH-1 activity and promote a pro-inflammatory TH-2 response, which in turn can lead to increased mucosal permeability, a situation that makes it easier for pathogens, endotoxins and food antigens to enter the neonate's bloodstream.[13]

Such disturbance of the gut microbiota can last months or even years—a critical period in immune system development—and may predispose a child to chronic inflammatory and autoimmune disorders.[13]

Absence or shortening of labor. The absence or shortening of labor in a cesarean section appears to affect a number of hormones that are known to play a role in stimulating the immune system at birth. In a vaginal birth, fetal hypoxia resulting from uterine contraction leads to a significant stress response, which in turn leads to very high catecholamine and cortisol levels in the neonate. These stress hormones play a key role in activation of the neonatal hypothalamic-pituitary-adrenal axis. A delay in HPA maturation could alter the early development of the immune system.[14]

In addition, the cord blood of babies born by elective CS (i.e., before onset of labor) has been found to be lower in neutrophils, lymphocytes and natural killer cells than that of their VD counterparts. Leukocyte activity is diminished as well; overall immune system function is hampered. Differences in lymphocyte function between CS and VD babies have been detected as late as one year of age.[14]

Although speculative at this point, it is possible that CS may also cause epigenetic alterations in the newborn that predispose to inflammatory disease later in life. Animal studies have shown that neonatal stress can lead to permanent epigenetic alteration via DNA methylation. A small Swedish study found that human infants delivered by elective CS had significantly elevated cord blood leukocyte methylation compared with VD newborns.[15] While the significance of these findings is unclear at present, it does suggest that the newborn epigenome is sensitive to perinatal influences.

Other factors. One factor for which CS may be a marker is antibiotics, which are known to cause marked and long-lasting alteration in the gut microbiota in infancy. As antibiotics are a routine part of a cesarean birth, it is possible that they (or other, as yet unidentified, iatrogenic factors), rather than the CS per se, may be responsible for at least some of the association between CS and chronic diseases.

Another factor is breastfeeding. Breast milk contains antibodies, leukocytes, probiotic bacteria and other immunologically active substances. CS is associated with lower rates of

successful breastfeeding, which may contribute to delayed or abnormal immune system development.[16]

Disease Burden

If cesarean section does have a causal relationship with a number of chronic inflammatory disorders—and to reiterate, this has not been proven—how much disease could it actually cause?

Take asthma as an example. In a 2008 meta-analysis of 26 epidemiologic studies, Bager estimated that 1–4% of asthma cases could be attributable to CS.[3] Approximately 7 million American children currently have asthma. Using Bager's figures, CS could be responsible for between 70,000 and 280,000 cases.

A 25% reduction in the U.S. cesarean rate (i.e., returning to 2001 levels) could mean 20,000 to 70,000 fewer cases of asthma over an 18-year period. If the cesarean rate were reduced to the WHO-recommended level of 15% of all births, the reduction in disease could be proportionally greater.

Prevention of a relatively few cases of asthma may not be the whole story, however. Unaddressed in Barger's analysis is the issue of disease severity in children who were destined to develop asthma regardless of mode of delivery. If CS does put children at risk to develop the disease, it follows that it could also worsen the disease in children whose asthma is primarily due to genetic or other factors. It's possible that a reduction in cesarean sections could mean less severe disease for those CS-born children who would have developed asthma in any case.

Conclusion

While cesarean section has saved untold numbers of lives en route to becoming a nearly routine alternative to vaginal birth in the early 21st century, it may be accompanied by unintended consequences that are only now becoming evident.

A significant majority of recent research studies has found that an association exists between CS and a mild-to-moderately increased risk of several chronic inflammatory diseases in childhood, including asthma, type 1 diabetes, and inflammatory bowel disease. The extent to which CS may contribute to the overall burden of these and other diseases is unclear at present.

In emergent cases, that additional risk is worth taking, but a note of caution is warranted in elective situations as researchers seek to fully understand the impact of CS on the developing immune system. To quote Dr. Jose Saavedra of the Johns Hopkins Bloomberg School of Public Health, "The increasing recognition of cesarean section as a risk factor for chronic conditions that manifest themselves far beyond the perinatal period should foster increased awareness of these risks, and serve as additional argument against non-medically indicated cesarean section." ◇

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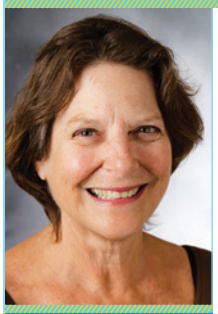

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The Space Between Home Birth and Hospital

Elizabeth Smith, CNM, MSN

On the first of January, people celebrate the New Year with parties, champagne and "Auld Lang Syne." For San Rafael couple David Chernus and Crystal Reed, Jan. 1, 2015, brought a far different beginning: the birth of their daughter, Franklynn Robin Chernus. Born at 1:10 a.m., the 7-pound, 19.5-inch infant was delivered at the Santa Rosa Birth Center and holds the honor of being Sonoma County's first birth of the year.

David Chernus, Crystal Reed and their daughter Franklynn.

Birth centers remain a source of confusion for much of the public, despite considerable evidence for their safety, cost effectiveness and patient satisfaction. The Bay Area is home to three birth centers and has two more in development. Santa Rosa Birth Center, the second-oldest birth center in the state, has served Sonoma County for more than 20 years. Berkeley's Pacifica Family Maternity Center opened in 2012, and Santa Rosa's Thrive Center for Family Wellness opened its doors last year. Marin City Health & Wellness Center, a federally qualified health center just outside Sausalito, plans to expand its services and open a birth center in late 2015. And the San Francisco Birth Center also targets this fall for its debut. Even with the increased presence of birth centers in the area, many people wonder what a birth center is, and what it seeks to do.

Ms. Smith, a certified nurse midwife, is the director and owner of the Santa Rosa Birth Center.

What is a birth center?

The American Association of Birth Centers (AABC) defines a birth center as a "homelike facility existing within a health care system with a program of care designed in the wellness model of pregnancy and birth." Birth centers operate in the space between home birth and hospital, combining the low-intervention, natural approach of home birth with access to a hospital if needed. Birth centers care for medically low-risk women before, during and after normal pregnancy and delivery and utilize an evidence-based risk assessment tool to identify when mothers become too high-risk for birth center care. Most birth centers also provide comprehensive women's health care that extends beyond maternity care and includes well-woman screenings, family planning and gynecological needs.

The goal of birth centers is to provide high-quality maternity care with a holistic, individualized approach. Practically speaking, birth center practices are small and offer a more intimate experience than a hospital. They focus on making the birth experience special, facilitating family involvement, limiting unnecessary interventions, and providing as much control and individualization as medically possible.

What are midwives?

Birth center care represents a collaborative model of health care delivery. Midwives, the primary providers, work with physicians and hospitals to provide comprehensive services. Midwives are medical professionals who have received extensive training in the care of healthy pregnancy and birth. They view childbearing as a normal physiologic process and focus their attention on maintaining normalcy within the context of evidence-based care.

While there are different types of midwives, the AABC states that most midwives practicing in California birth centers are certified nurse midwives (CNM). CNMs are registered nurses with graduate-level education in midwifery; they have passed a national board certification exam and provide

general women's health care throughout a woman's lifespan. California CNMs have full prescriptive authority, enter into insurance contracts, maintain malpractice coverage and can hold hospital privileges. Many birth center CNMs hold concurrent credentials at their local hospital so they can care for patients who prove too high-risk for the birth center facility. The AABC Birth Center Standards require accredited birth centers to disclose the type and qualifications of the providers rendering care at the birth center.

All CNMs employed at the Santa Rosa Birth Center also attend births at Sutter Santa Rosa Regional Hospital. Likewise, certified nurse midwives own and will staff the future San Francisco Birth Center. Midwives at Santa Rosa's Thrive Center for Family Wellness and Berkeley's Pacifica Family Maternity Center are licensed midwives (LMs) and certified professional midwives (CPMs). They have a slightly more limited scope of practice and attend births both at the birth center and at home. Marin City Health & Wellness Center promotes a unique, open-model birth center. Staffed primarily by licensed midwives, its birth center will credential community physicians and midwives, allowing outside providers to attend birth center patients.

All midwives rely on their physician colleagues to collaborate, co-manage or accept care of women who require treatment beyond the well-defined scope of midwifery practice. Indeed, the Standards of Birth Centers published by the AABC requires that a physician-midwife relationship exist in order to provide safe and effective care. Santa Rosa Birth Center has a formal relationship with the physician members of the Santa Rosa Community Health Centers obstetrics team that allows for consultation and/or transfer of care if needed. Pacifica's medical director is a Board Certified OB-GYN who provides collaboration and co-management for its clients. The Marin City Health Center physicians and nurse practitioners will provide collaborative services for their pregnant patients. In addition to

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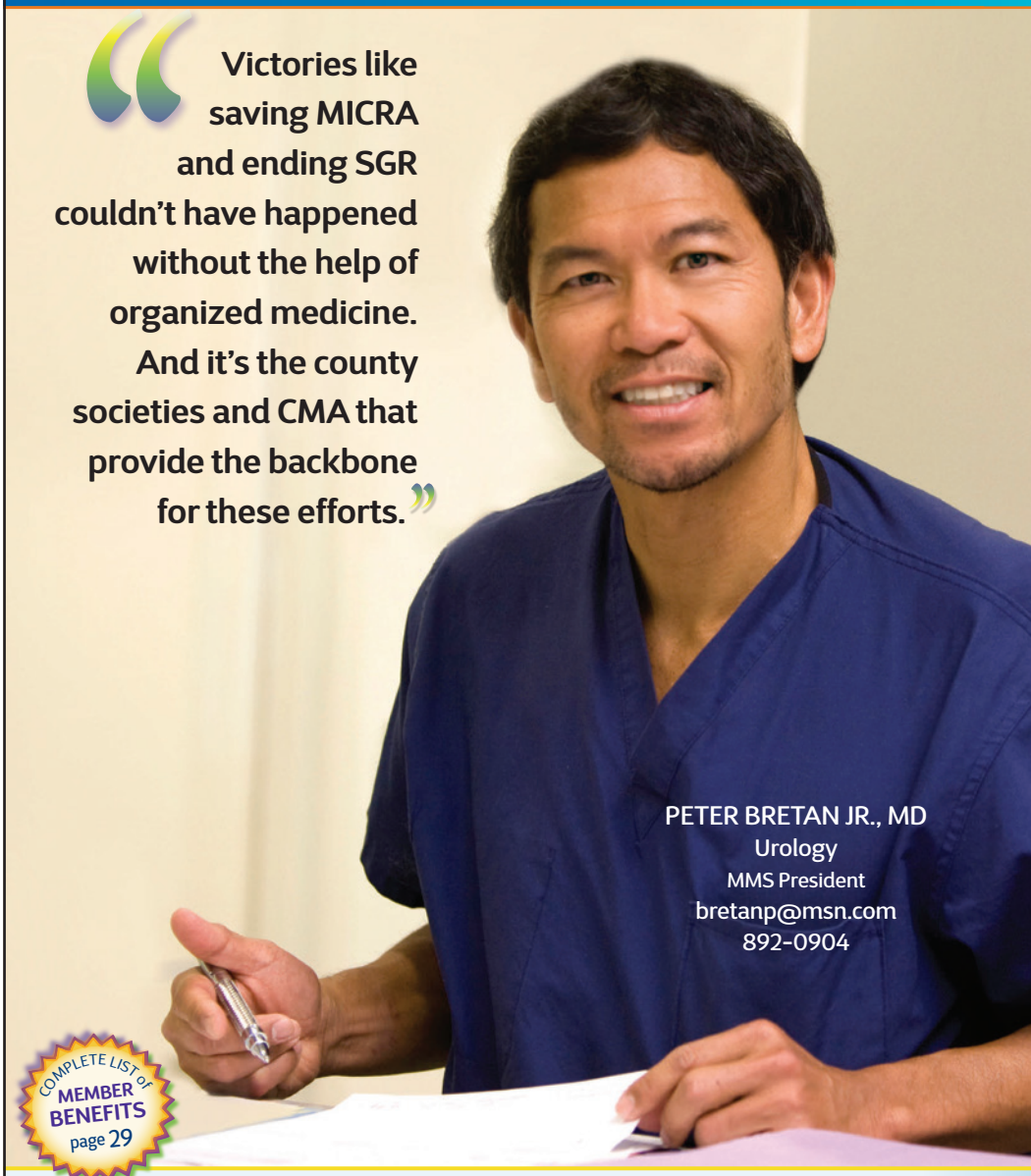

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these formal relationships, midwives also maintain informal collaborative relationships with community obstetricians, pediatricians and neonatologists.

In addition to medical providers, the birth center model includes an interdisciplinary team to provide direct and ancillary support services. These roles can include educators for classes on childbirth and parenting; trained therapists to address family needs as they arise; and lactation support specialists for postpartum breastfeeding support. Birth centers also offer services like yoga classes, birth plan assistance and informal support groups. The focus is client-driven care across a full spectrum of interests.

Are birth centers safe?

"But what if something happens during labor?" As with hospitals and outpatient surgery centers, regulations and published standards of care dictate the specific training, supplies and medications that birth centers are required to have for each delivery. Careful, ongoing monitoring of mom and baby, as well as emergency medications, IV fluids, resuscitation equipment, and established physician and hospital backup provide the necessary backdrop to all care. In an emergency situation, providers and staff are trained and experienced in the provision of emergency care and stabilization while awaiting EMS transport. This includes the administration of emergency medications and full neonatal resuscitation according to American Academy of Pediatrics guidelines.

Several well-designed studies have established the safety of birth center care. The recent National Birth Center Study II,[1] a prospective study of over 15,000 women in 79 midwife-led birth centers across the country, found a 16.8% maternal transfer rate, 6% cesarean section rate, and intrapartum fetal and neonatal mortality rates of 0.47% and 0.04% respectively. It is important to note that the National Birth Center Study II did not include a hospital cohort for comparison. However, these findings are consistent with other studies comparing location of birth, midwife-led care and obstetric care, all of which corroborate that midwife-led birth center care is a safe option for medically low-risk women.[2–8]

Birth centers use a model of care that supports wellness and physiologic birth and a diligent practice of risk assessment. This combination works to keep women healthy and low-risk while allowing early detection and treatment of potential complications. Identifying those women for whom a birth center birth is not appropriate lies at the base of this approach. The collaborative model of care allows co-management of these higher-risk pregnancies in the hospital by a CNM and a physician. Other times, risk guidelines necessitate the complete transfer of care to the physician collaborators.

A case study: Safety at the Santa Rosa Birth Center

In the Santa Rosa Birth Center's 21-year history, CNMs have overseen 3,422 births. In 2014, they managed 138 births. Of 101 laboring women admitted to the Birth Center, 84 births occurred within the facility. Fifty-four Birth Center clients delivered in hospital. Of these births, six were managed by Birth Center CNMs and the remaining 48 were managed by the collaborating MD/CNM hospital practice. Thirty-seven were planned hospital births and 17 (16% transfer rate) were transferred in labor or postpartum after admission to the Birth Center. Of the 17 transfers, two were transferred because of failure to progress and one for postpartum bleeding. There were no maternal or fetal/infant deaths, and the cesarean section rate for all Birth Center patients was 6%.

These outcome data are comparable to those for all the births at the Birth Center since its inception in 1993. Furthermore, the 2014 statistics compare favorably with national data published by the CDC, as well as data from the National Birth Center Study II.[1]

There are other benefits of birth centers beyond positive medical outcomes. One of the most striking is the breastfeeding rate. Ninety-nine percent of Santa Rosa Birth Center clients are breastfeeding at six weeks postpartum; 97% are exclusively breastfeeding. At one year postpartum, 55% continue to breastfeed.

How are birth centers regulated?

A common misconception is that birth centers have no external regulation or governmental oversight. This simply is not true. In addition to being subject to local, state and national laws concerning the practice of medicine and midwifery, the AABC publishes the Standards for Birth Centers, which forms the foundation for the safe functioning of birth center facilities. An independent authority, the Commission for the Accreditation of Birth Centers, uses these standards to evaluate birth center care and to accredit individual birth centers. While some states, including California, permit birth centers to operate without accreditation, most birth centers are accredited through the CABC. The Santa Rosa Birth Center has been accredited since 1997. Pacifica earned accreditation in 2013, and accreditation for Thrive Birth Center is in process.

In addition to national accreditation, California licenses alternative birth centers through the Department of Public Health, but does not require this licensure for business. California-licensed birth centers are required to comply with the state's Health and Safety Code, which mandates that birth centers, among other things, adhere to the AABC Standards of Care and undertake the voluntary process of accreditation. The Santa Rosa Birth Center is the only licensed alternative birthing center in the Bay Area.

How much do birth centers cost?

Because of the nature of birth center care—its "low tech" approach, smaller physical facility and lower overhead—the cost of a birth center birth is significantly lower than that of a hospital birth. Most birth centers work with insurance plans to maximize coverage for services rendered. In California, Medi-Cal reimburses birth center facil-

ity fees, as well as maternity services provided by CNMs. Insurers—such as Anthem Blue Cross, Blue Shield, Cigna, Aetna and United—also cover care rendered by midwives in birth centers as well as the birth center facility fees.

On a larger scale, the cost savings of birth center care is a primary reason advocates for health care reform embrace the birth center model. The National Birth Center Study II estimates that the cost savings from reduced cesarean section and lower intervention rates among the 15,000 study participants came to nearly $30 million.[1]

Who seeks birth center care?

"We wanted as natural and noninvasive a birth as possible," says Crystal Reed when describing her family's reasons for choosing a birth center. This desire for a natural birth is frequently expressed by birth center clients. Although some people choose birth centers to reduce costs, most choose this type of care because they want a natural, physiologic birth. Parents who choose a birth center prefer to avoid the perceived inconveniences of the hospital: unknown staff; unfamiliar routine and invasive procedures; lack of flexibility to respond to family desires; routine separation of mom and baby; and requirements for a prolonged postpartum stay.

During a pregnancy, the nature of birth center care allows families to develop a relationship with their midwives that fosters trust and a sense of safety. The birth center facility is important as well. It is a homelike environment. Mothers can labor in an atmosphere that is familiar rather than clinical. They can return to their own home within six to eight hours of birth if baby and mom are doing well. They know that going home is safe because they can call the midwife at any time and will receive a home visit within the first 24 hours and regularly throughout the first week.

There is no one-size-fits-all when it comes to birth. The decision of where to give birth and how is an intensely personal decision that should be based on the desires of the pregnant mother in collaboration with her family and health care provider. In most instances, an otherwise healthy woman with a low-risk pregnancy is a candidate for a birth center birth. But pregnancy and birth is a dynamic experience influenced by a woman's medical condition, emotional needs and fiscal reality. Birth centers exist as part of the health care system, not outside of it. When licensed and accredited, they are a safe and cost-effective alternative to hospital or home birth, and represent one option on the continuum of birth choices. ◇

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Healthy Weight, Healthy Pregnancy

Gail Altschuler, MD

Physicians understand the negative health consequences of being overweight, including a higher incidence of heart disease, diabetes, cancer and back pain, to name a few. Another consequence is the effect of weight on fertility, fertility treatment and pregnancy, as well as the ongoing health of mother and child.

Infertility, for example, is significantly higher in women who are overweight, and it increases as their BMI rises.[1,2] Attempts to become pregnant through escalating interventions become ever more physically, financially and emotionally costly. These costs become statistically significant, and they are more pronounced at higher BMIs, especially if there is central obesity.[2]

Obesity brings multiple physiologic changes that affect fertility and pregnancy, including changes in estrogen, testosterone and LH/FSH ratios. Leptin, insulin and multiple inflammatory cytokines are also affected. These contribute to abnormalities of ovulation; abnormal egg, embryo and endometrial development; unsuccessful implantation; and failure to maintain a viable pregnancy.

Dr. Altschuler, a family and bariatric physician, is medical director of the Altschuler Center for Weight Loss & Wellness in Greenbrae and Novato.

Male fertility is also negatively affected by obesity. The prevalence of male infertility is increasing, as evidenced by decreasing sperm counts throughout the world. It has been estimated that sperm counts have fallen by as much as 1.5% each year in the United States, a finding also noted in other Western nations.[3] Health, volume and motility of sperm are all affected. Although the cause is uncertain, proposed explanations include increasing obesity and exposure to environmental toxins.

Women who are underweight (BMI <19) often have difficulty conceiving as well. After ruling out underlying illness or eating disorders, it is generally easier for this population to reach an ideal weight and improve their odds for conception. For all groups, an ideal body weight results in the best outcome for fertility and fertility therapy, as well as maternal and fetal health.

Other potential complications that overweight and obese women face around pregnancy and birth include:[4,5]

- Irregular periods
- Difficulty or inability to conceive
- More complicated IVF cycles
- Lower IVF success and greater complications of pregnancy for those who do conceive
- Higher frequency of early pregnancy loss
- Greater anesthesia and surgical complications if surgery is required
- Greater frequency of hypertension, gestational diabetes, preeclampsia, stillbirth and other complications of pregnancy. Rates of stillbirth are twice as high in obese patients as in normal weight patients.
- Increased risk of cesarean section delivery. The C-section rate is almost 50% in obese women, and the postoperative complications following C-section are significantly higher as well.
- Due to larger babies, greater delivery complication rate for women delivering vaginally.
- Lower prolactin leading to decreased nursing
- Higher risk of maternal diabetes

Consequences for the newborn into adulthood include fetal macrosomia, pneumonia, lifelong risk of obesity and its consequences, behavioral problems, and risk of asthma.[6]

In the face of all these potential complications and adverse effects, reduction in BMI through weight loss has been demonstrated to improve fertility and fertility therapy success and to lower complications of therapy and pregnancy.

Women often ask for help with weight loss when they are considering pregnancy. Many of them understand that pregnancy will be easier if they don't carry extra weight.

Recently I helped care for a patient who had tried unsuccessfully to become

pregnant during the past year. I chose her as an example because she might not be considered a typical candidate for weight-loss therapy, yet the intervention in her case turned out to be simple and effective.

She had already been to an infertility specialist and was told she had a fibroid uterus. She had a long history of irregular or missed periods and a diagnosis of polycystic ovary syndrome. Her initial BMI was only 26.5, but her waist circumference was 36 inches. (Central obesity is often characteristic of women with impaired fertility.) The patient also had a high-stress job, many hours of driving and little physical activity.

She started on a 1,200 calorie low-fat diet, avoiding refined carbohydrates (the whites: white sugar, white flour, white rice, and white potatoes because of all the toppings). I advised her to eat small, frequent servings of protein throughout the day. She also began phentermine at one-half of a 37.5 mg tab daily. She delayed pregnancy for several months during the active weight-loss phase. She resumed regular physical activity and started yoga. She was seen every two to four weeks for monitoring, and I adjusted her program as needed.

At her six-month follow-up exam, she had lost 12 pounds, her menses had returned to normal, and she was feeling better than she had in a long time. Her husband also lost 25 pounds. (When women take better care of themselves, it is common for the entire family to benefit.) Medications were stopped, and she continued to lose weight following a program of reduced calories, optimal protein, regular physical activity, and yoga for stress management. Six months later she happily reported she was eight weeks pregnant. After five months of pregnancy, she was 10 pounds lighter than at her initial visit.

This case illustrates the tremendous opportunity physicians have to influence weight loss in women before and during pregnancy. The U.S. Preventive Services Task Force recommends making height and weight measurements part of vital signs.[7] They also recommend recording waist circumference for people with a BMI over 25. These actions go a long way toward letting patients know the importance of achieving and maintaining a healthy weight; they also alert patients to potential risks. People are often surprised to learn what weights are medically considered overweight, obese and extremely obese.

Beginning weight counseling early, long before pregnancy is contemplated, makes a big difference. It's easier to lose 10 to 30 pounds when a patient is younger, and changes made at this time of life can have a positive effect far into the future. Eating more protein, much less sugar and avoiding refined carbohydrates can result in significant weight loss. Even weight loss of 5–10 pounds can improve health and metabolic parameters.

Anti-obesity medications can be a helpful tool when used with a comprehensive program. Patients who have a significant amount of weight to lose often do better with medications. All weight-loss medications are contraindicated during pregnancy, but they can offer a significant advantage when used selectively and carefully monitored with patients who are considering a pregnancy that might otherwise be impossible.

Several weight-loss medications have recently been approved by the FDA, making it easier for primary care physicians and OB-GYNs to prescribe them. The medications include phentermine-topiramate (Qsymia), lorcaserin (Belviq), wellbutrin-naltrexone (Contrave) and liraglutide (Victoza). Each offers a different approach to a complex problem. Some older medications, such as phentermine, diethylpropion and phendimetrazine, have a long history of safety and effectiveness. Patients must use appropriate contraception during this active weight-loss phase.

For pregnancy itself, clomiphene has long been considered first-line therapy to induce ovulation. Metformin plays a role in managing infertility caused by polycystic ovary syndrome (PCOS), an endocrine abnormality that, through numerous proposed mechanisms, leads to anovulation.[8] Although the comparative results of clomiphene vs. metformin have differed, a 2009 meta-analysis showed no difference between the two treatments in terms of ovulation rate, pregnancy rate, or live birth rate.[9] When clomiphene plus metformin was compared with monotherapy with each agent, combination therapy was no more successful than monotherapy.

Patients who are candidates for metformin therapy must be made aware that it induces ovulation indirectly, taking up to six months to improve ovulation.[9] Clomiphene, in contrast, acts directly by producing a surge of luteinizing hormone and could cause ovulation within days.[9]

Bariatric surgery may not typically be considered when discussing planning pregnancy, but in the severely obese woman, bariatric surgery can greatly improve her odds of conceiving, either naturally or assisted. A positive outcome of pregnancy is also directly linked to the degree of weight loss.

A small cohort study reported at the 2011 meeting of the American Society of Metabolic and Bariatric Surgery showed that PCOS symptoms improved significantly after bariatric surgery, and previously infertile women successfully conceived. Almost all the patients had resolution of menstrual dysfunction, and fewer reported hirsutism. Every infertile woman in the study who wanted to conceive did so postoperatively, either naturally or by assisted reproduction. On the other hand, a 2009 practice bulletin from ACOG concluded that, "Bariatric surgery should not be considered a treatment for infertility." I, personally, disagree with this statement. There is still significant prejudice against overweight people. Surgical options should be presented, as part of the spectrum of comprehensive care, to anyone whose weight is keeping them from a healthy, successful pregnancy.

For women who have been unable to become pregnant, weight loss may be all that's needed. The closer women get to their ideal weight, the better their chance of success. There are many reasons for infertility, however, and weight loss and lifestyle changes will not address all of them. Nonetheless, weight loss is one of the most powerful and effective interventions. In my experience, just reducing insulin resistance with proper diet and physical activity can make the difference.

Weight loss can help restore a healthy hormonal balance in both overweight and obese men and women. It can create an environment where the odds of becoming pregnant naturally, as well as the success of infertility treatments, are optimized.

Here are some suggestions for making weight management part of a busy practice:

Ask permission to discuss weight. A few nonjudgmental questions can initiate a powerful partnership. "Would it be all right if we discussed your weight?" or "I'm concerned about your weight because I think it might cause health (or pregnancy) problems down the line" are a good place to start. Preferred words and phrases, such as *unhealthy weight* or *excess weight*, are better accepted by patients than words and phrases like *obese*, *fat* or *large size*.

Make your office welcoming to overweight patients. Use scales that read higher weights, large-size gowns, and chairs that are comfortable and fitting. Respect their privacy and remain sensitive to how you speak about their weight as it impacts their health. Make weight, BMI and waist circumference part of routine vital signs as appropriate.

Begin counseling early. Begin educating and counseling on the benefits of achieving and maintaining a healthy weight long before pregnancy is desired.

Provide monthly follow-up. Patients who are actively in a weight-loss phase need regular follow-up extending through maintenance.

Refer if necessary. Patients with complex weight-loss needs may need referral to a specialist.

When seeing an overweight or obese woman choosing to become pregnant, offer counseling and recommendations for appropriate calorie and nutritional intake, plus physical activity. Handouts work well at this stage. Patients who are in an active weight-loss process should be seen every two to four weeks for support and guidance. Often these visits can be done by a nurse or medical assistant; minimal extra training is required.

If these efforts are unsuccessful or the patient has significant weight to lose, refer them to a dietitian, community weight-loss program or specialist. In my experience, a physician's interest in a patient's weight loss frequently results in a positive response. ◇

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2015–16 MMS President Peter N. Bretan Jr., MD

Howard E. Daniel

When this interview was conducted, Peter Bretan, MD, was preparing to assume the presidency of the Marin Medical Society for the fourth time. He previously headed MMS in 2006, 2010 and 2011. He was born in 1954 to immigrant parents from the Philippines who grew vegetables and strawberries in Pismo Beach. From age 6, he worked as a farm laborer.

Dr. Bretan earned his BS in physiology from UC Berkeley in 1976 and his MD from UCSF in 1980. He remained at UCSF from 1981 to 1986, completing a residency in urology as well as a postdoctoral fellowship in radiology. He then went to the Cleveland Clinic where, in 1986-87, he completed a fellowship in transplantation and renovascular surgery. He remained on the Cleveland Clinic urology and renal transplantation staff from 1987 to 1989, during which time he was simultaneously a doctoral candidate in molecular biology and physiology at Case Western Reserve University. In 1988-89 he also served as renal transplantation director at St. Elizabeth Hospital in Youngstown, Ohio.

Dr. Bretan returned to California in 1989, where he first served as surgical director for pancreas and renal transplantation at Harbor/UCLA Medical Center and as assistant professor at the UCLA School of Medicine. In 1992, he moved back north and served as associate professor of urology and surgery at the UCSF School of Medicine, where, from 1994 to 1996, he was also director of the Kaiser-UCSF Transplant Service and performed nearly 100 transplants a year. In 1999 he entered private practice in Novato. He also instructs pre-med and medical students at UC Berkeley and Touro Medical School, where he is adjunct clinical professor.

He has published over 200 scientific articles on both clinical and original research subjects, winning multiple academic awards. He speaks internationally as an expert in kidney transplantation as well as prostate and bladder diseases. He also serves as a reviewer for six clinical and scientific journals—for the past 30 years he has reviewed or screened all submitted abstracts for the transplant sessions at the American Urological Association's annual meetings and he regularly moderates many of its sessions.

Dr. Bretan is the founder of Life Plant International (www.LifePlant.org),a charitable organization that promotes disaster preparedness, organ donation and early disease screening worldwide. LPI medical missions to the Philippines since 2002 have included performing and teaching kidney transplants and laparoscopic kidney removals, saving many lives. Also a captain in the U.S. Public Health Service Reserves, Dr. Bretan has served on missions over a 25-year span, including as Team Orleans' lead surgeon following Hurricane Katrina in 2005.

Dr. Bretan and his RN wife Melanie Jean Bretan have four grown children—Jon, a physicist; Anna, an obstetrics nurse (with three of her own children: Mason, 9; Preston, 7; and Tatum, 3); Mason, a doctoral candidate at Georgia Tech; and Mark, a recent graduate of the San Francisco Academy of Art.

This interview was conducted in Dr. Bretan's office in Novato on April 15.

What made you decide to become a doctor?

When I was 8, my father was in a local hospital with impacted gallstones. He was so unstable that no one there dared operate on him, fearing he would die on the operating table. He had already been given last rites, and my aunts were telling me, a frightened kid, that I would soon be the man of the house. My dad was a World War II veteran, and in desperation, his doctors sent him to Sepulveda VA Hospital, which was affiliated with UCLA. They hoped someone there might be able to help. And one of the UCLA surgeons did. He tried a new procedure that had hardly ever been done anywhere—a staged procedure that worked!

As the surgeon walked toward my family, we all thought we were about to be told my dad had died. But the surgeon smiled and told me, "Your dad's going to be OK. We tried something, and we were able to stabilize him. I think he's going to be well." As the surgeon walked away, I just kept staring at him and thinking, "Whatever it takes, I'm going to be one of those guys, somehow." And all I've ever wanted to do since then is save lives and change lives.

That surgeon's simple act of kindness—trying a new, unfamiliar procedure to save a life—made him my lifelong hero and inspiration. I can never repay that act,

Mr. Daniel is the editor of Marin Medicine.

but I try to pay it forward. I know I would not have developed into the surgeon I am today if that hadn't happened, because I know what it is to be on the receiving end of a lifesaving act.

I think medicine is one of the noblest of all professions. There's no other profession that gets to save lives on a daily basis. Health care is a right. But for those who practice medicine it's a blessing. We get the privilege of being with patients . . . of saving lives . . . of changing lives.

What drew you to the practice of urology and your specialization in transplants?

I always wanted to be a surgeon. But surgery is a technical thing. Transplants, however, are a miracle. It's incredibly intense, and miraculous at the same time, to be able to move an organ out of one body, put it in another body and save a life. I mean, that's really exciting, even just talking about it!

And it was never done until relatively recently!

I was born into it. 1954—the year I was born was the year they performed the first successful transplant.

What organ was that?

A kidney! At the Peter Bent Brigham Hospital in Boston. Joseph Murray received the Nobel Prize for it in 1992. It had been tried 17 times before that. It seemed a miracle at the time! Immunology and immunosuppression were born around the same time, hand-in-hand with transplantation. The coming together of several different specialties!

I started off as a general surgeon. And it's not that I didn't like general surgery, it's just that being able to transplant organs and immunology were my long-term goals, and I found urology fascinating. And you could go into urology and become a transplant surgeon. So it would help me achieve my goals.

Urologic procedures impressed me as innovative. For example, you could take a piece of intestine and create a new bladder to replace a cancerous one. General surgeons didn't do that! Repairing organs out of other organs! Additionally, transplanting organs was pretty amazing. While it was competitive to secure a fellowship in transplantation, it was always my dream. With just two to three extra years of training, being a transplant surgeon was worth it.

Postop Day 1 for Dr. Bretan's patient, who underwent a laparoscopic donor nephrectomy. The patient donated her left kidney to her sister for transplantation. Photo by Lisa Fish.

And the most important thing was that I could save more lives doing it. That was the bottom line, saving lives. Just like the surgeon that saved my father's life.

You've been in practice since 1986. What medical advances, if any, have improved your ability to care for patients over the past three decades?

You know, when I started out as an intern, the overhead PA speaker would announce, "Dr. Peter Bretan, outside call!" And then technology gave you a little longer leash with the development of the beeper. But with the beeper, you still needed to be near a phone. Six years later, as an attending transplant surgeon, I got one of those very early "brick" cell phones.

I then started commuting back and forth between the Cleveland Clinic in Cleveland and St. Elizabeth Hospital in Youngstown, Ohio, an affiliated transplant center about 90-100 miles away. I would be on call for transplant surgery or transporting organs for transplantation, and if I got caught in a snowstorm with the kidney or other organs I was transporting, surgery would be delayed. So they gave me this first cell phone, and I thought it was a great technological asset. But cell services were awful.

Now, fast forward to today. Everyone has a cell phone. And everything's quick. Email or text. How could we function without these things today? And now, through this computer or my laptop, I can admit a patient into a hospital and put orders in from wherever I can get onto the Internet, and I can see the patient on my laptop later. I can check the labs right on my computer—no more getting put on hold for 15 minutes. I can check the labs on 10 different patients from six different hospitals at the speed of light. That's technology!

The other part of technology is that I can cover six different hospitals with telemedicine robots. I'm one of only a few people that have that capability. It lets me see a patient at a moment's notice up in Willits 150 miles away and admit them using my avatar robot persona. That's a huge technological feat! And when I'm in the Philippines on a medical mission, I can actually see patients here in the USA, admitting them from the other side of the world.

And we're at the cusp of still further technological surges.

Does technology have any downsides to it?

Well, some aspects of technology are a step back. For instance, we all complain about electronic medical records. Because it's tied us down and increased the amount of time we have to put in without helping us see patients. The way we're using it doesn't save time.

We have to find a way to deliver care efficiently up front. When technology can improve up-front delivery of medical care, that would take care of the problem of back-end low reimbursements. Reimbursement per patient might be lower, but if you're seeing many more patients safely and effectively, the compensation issue goes away!

That's what usually happens with new technology. Look at widescreen televisions and how much the price has dropped. Look at computers! It's just a matter of time before we do the same thing in medicine.

Right now with EMR, we have doctors inputting data. Shouldn't the patients or an intermediate person be inputting a lot of that data and the doctors just reviewing it? Then we could spend more quality time with patients talking about their symptoms and treatment. New technology and thus EMR should free up more time!

We don't see that investment in technology paying off yet because it's still in its infancy. So there are a lot of things we need to fix. Can we fix them? Of course we can. Is it painful right now? Absolutely. We're going through growing pains.

I want my young medical students and my colleagues to know: Yes, it will get better! We need to push together to help make it better. We should demand it through health care policy.

What about telemedicine? Is that going to have a positive impact?

There is a lot of "telehealth" going on out there that is really no more than tele-advertisement for health! Let me give you an example. I once saw an ad from a medical center, which claimed: "Come to our site and talk with the five smartest docs in the world!" And what you get is basically a gimmick to sell you something or pull you in on referral.

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I do something entirely different with my telemedicine robot. I use it with patients, and when I'm with a patient via robot, I'm responsible for that patient. There is no difference in terms of legal liability between my seeing a patient in person and seeing that patient with the help of a telemedicine robot. This is real telemedicine. An actual doctor-patient relationship is established and is ongoing.

Look at this [pointing to a computer screen]! Here's telemedicine! Wherever there's wi-fi, I can manage this robot at one of the hospitals I cover. So I can cover Marin, Sonoma, Mendocino, Lake—all these hospitals within 150 miles where I have privileges. And I'm the only urologist in six of them.

In a *Marin Medicine* interview you did in 2010, you mentioned that you want to make your skills available to people in relatively sparsely populated parts of the state . . .

This is the sparsely populated part of the state. Northern California, all the way up to the Oregon border. Maldistribution of specialists is worse in rural areas. For example, 20% of the U.S. population lives in rural areas, while only 9% of the doctors do. So there is a significant rural maldistribution of physicians, coupled with lack of specialist care. But with technology we can bridge this gap. Without telemedicine, most urologists would not see patients more than five or 10 miles from their offices.

How far north do you go when you do a physical procedure?

I go to Willits, Clear Lake and Fort Bragg on a regular basis. But I provide immediate assistance electronically. Patients can reach me 24/7.

When I work with patients with the help of my robot, they understand me just as if I were in the room with them! And if I sense they don't want to follow my directions, I let them know they can get a second opinion. If they go with another doctor, that ends my responsibility, my liability. What we're doing, whether in person or via telemedicine, is protecting the patient. It's a patient-centric, doctor-patient relationship. We have to protect that, and we are going through a period of growth and change right now.

Among your many other activities and interests is basic academic research, the pursuit of which has led you to patent two organ-flush solutions. Tell me about the professional satisfaction of doing research. And are you still involved in research?

I still do some clinical research, yes. Let me explain. In whatever I do, my motivation is simple. It's to save lives. You can always crunch that down, what motivates me. When I'm doing surgery in my practice or on medical missions abroad, it's one life at a time. But if you publish a paper or patent something you're eventually saving hundreds, maybe thousands of patients! There is great personal enrichment in doing research. I learned that at UCSF from my urology chairman, Dr. Emil Tanagho, who developed many urologic procedures. I asked him why I should think about doing research. "You might help save many lives!" he told me.

Now in a free, democratic society, science doesn't always make everybody happy. A perfect example of this is the measles outbreak! The science is there . . . and you can take a horse to water, but you can't make him drink. We have to get rid of this nonsense. And that's what

Richard Pan is doing. He's a physician, a pediatrician who's in the State Senate, and he introduced the bill to keep parents from exempting their kids from school vaccination requirements on the basis of personal beliefs not based on science. As a result he's coming under attack from some unreasonable parents. But safeguarding public health is essential, and that's the first responsibility not only of government, of course, but also of organizations like ours—the Marin Medical Society and CMA.

What do you see as the major medical challenges in Marin County, and how do they differ, in your view, from challenges around the state and across the country?

In Marin it's vaccination. And parental waivers based on "personal beliefs." Otherwise, we have the same challenges as the rest of the state, the rest of the country. We are implementing the Affordable Care Act, which is broadening coverage and decreasing the number of uninsured. That's got to be a good thing.

Another problem is the inadequate reimbursement of doctors who treat Medi-Cal patients. With the help of Assembly Health Committee Chair Rob Bonta we have a bill out there that not only restores the 10% Medi-Cal reimbursement cuts, but increases reimbursements further, so they're on par with Medicare payments. I think that's the backbone of meaningful implementation of the Affordable Care Act, because the best way to increase the health of a population is to increase people's access to primary care doctors. Two-thirds of all care is from primary care docs, and improving access to them could decrease emergency room visits, etc. We have to make sure the primary care docs don't go bankrupt before our work on this is complete. In fact, one of the major campaigns just launched by CMA is to fully fund Medi-Cal for our patients. I feel that these health directives support the backbone of efficient health care delivery, leading to healthier and more productive California communities.

If we need more doctors, are the medical schools supplying enough physicians to meet the demand?

We can always use more doctors. But, as I said, the problem is in maldistribution. And it's also that delivery of care is still hindered by aspects of electronic medical records that have taken time away from face-to-face contact with patients.

You have to work in concert—increasing the number of docs, increasing the distribution of docs in rural areas, increasing time available to work with patients, and increasing reimbursement for physicians who work with the indigent and Medi-Cal patients so they can keep their doors open.

And, by the way, most of the care being provided for the indigent and Medi-Cal patients is through solo practitioners or small-group practices. I am a solo practitioner. We're all hard hit! And I don't have a big lobby system. So I have to rely on the medical society to look out for my interests. That is why solo practitioners and small practices need to be shown that they should be part of the county medical societies and the CMA. In terms of funds spent on lobbying to affect health care policy in Congress, the AMA is second only to the American Hospital Association with each one investing about $20 million. Who's going to represent doctors better in terms of lobbying and bringing about needed changes?

> *"The best way to increase the health of a population is to increase people's access to primary care doctors."*

In an interview with *Marin Medicine,* one of your predecessors as MMS president, Dr. Irina deFischer, said that it can often be difficult for patients to access the community clinic safety net because they can't get appointments or they have to travel too far or they can't afford the copays. Is this problem likely to be resolved anytime soon? To what extent might ACA make community clinics superfluous by allowing the previously uninsured easier access to other providers?

Medi-Cal pays doctors $22 per patient visit compared to federally qualified health centers (FQHCs), which are paid $157 per visit. These clinics tend to be overburdened, but they're getting adequate funding from the Feds. Increasing the Medi-Cal payments for doctor visits would help alleviate most of these inequities and open access to care for many waiting patients. This is the solution and it is what we should probably be doing, and hopefully can do in the near future. Although it was not specifically laid out in the Affordable Care Act, correcting this would even out most of these access discrepancies. Delay in health care is expensive, while providing access, especially to the indigent, would be very cost-effective. Thus to fund Medi-Cal at the small-practice and solo-doctor level would be very efficient. And that is why we're lobbying for that right now, both in the AMA and the CMA.

It's very difficult to take care of patients at $22 a visit. You'll go bankrupt. You'll have to close your doors. And once those doors are closed, it's not likely they'll reopen. A lot of doctors have to control the number of Medi-Cal patients they have because it's almost pro bono. You can't just say, "OK, I'm opening my doors and I'm going to take time away from the insured people." Everybody does that to some extent, and you have all of these programs. But the funding is not available for the ordinary doctor out there right now. Hopefully it will be soon.

We have to tackle one thing at a time. Congress fixed—repealed!—SGR, Medicare's Sustained Growth Rate provision, last night [April 14, 2015, the day before this interview took place]. So now we can stop worrying about having our billings cut 21%, which we have had to do for the past 15 years.

This, to me, and laws like the one Assemblyman Bonta has proposed to shore up funding for Medi-Cal, are fundamental to fixing care for low-income

people and the indigent. If we can fix that, it would significantly decrease the health care disparities that disproportionately hurt the poor.

Hopefully, we can increase other reimbursements too. It's not only primary care docs. We don't have enough reimbursement for specialists seeing Medi-Cal patients either. As one of those specialists, I get almost nothing. If I ask for reimbursement, it costs me $5 to get $3 out of Medi-Cal. You just do things and don't charge because you're not going to get anything anyway. So, yes, we need to fix that.

How do you view the ways the Marin Medical Society serves the physicians of this county? What are the primary benefits it brings them?

There are three big areas where CMA's lobbying efforts help physicians: financial benefits, scope of practice benefits, and implementation of ACA and public health.

The big financial success last year was winning voters' support for MICRA, the Medical Injury Compensation Reform Act. When the lawyers got MICRA on the statewide ballot, polls showed that 60% of those surveyed supported the lawyers' position. If it had passed it would have raised the average surgeon's malpractice insurance premiums from about $30,000 to almost $150,000 maybe even $200,000. So with the "No on 46" campaign we saved MICRA and actually won the vote, 70% to 30%.

The most important thing that CMA did was to organize thousands of members and organizations to create the backbone of an effort that the insurance companies then supported with money. We raised $100 million altogether to fight this, of which CMA put in $5 million, including the seed money needed to form the winning coalition. The rest came from the insurance industry, hospitals and other organizations. It was a costly undertaking.

Could anybody have done that except a medical society that speaks for all doctors? I don't think so. We took on the full weight of the trial lawyers, but fortunately patients still believe doctors do more for their health than trial lawyers, so we won!

> *"MICRA was . . . about access to care. . . . Without that, 'more people would die.' Some 20,000 Americans die every year from lack of access to care."*

We won by advocating for our patients' access to health care, and if that had been compromised, lives would have been lost.

And then there's last night's fix on SGR. I'm so proud of that. The AMA, with the support of the CMA and the other state associations, has been fighting that for a very long time. Just imagine if I were to tell you every six months, "Hey, I'm going to cut 21% from your paycheck retroactively. You might even wind up owing money." Most doctors don't have that kind of money in their practices. And most of us don't want to take money out of our mortgage to sustain our practice. We'd rather just fold. But that's the way we've been obliged to practice medicine for almost 20 years. That threatened 21% cut drove a lot of my primary care doc colleagues into group practices because they just couldn't live with it.

These financial benefits have helped doctors keep practicing their craft and saved them a huge amount of money. Victories like these could not have happened without the help of the county societies and CMA, which provide the grass-roots support for these efforts.

What do you mean by scope of practice benefits?

These are efforts the CMA and AMA make to protect physicians' scope of practice—to prevent things that could erode a practice—for example, the efforts of optometrists to be allowed to operate on the eyes. That would dilute medical practices. For example, ophthalmologists undergo seven or eight years of medical training, including three or four years of surgical residency, whereas optometrists get just four, or sometimes five, years of medical training, with far less preparation for surgery. Would the public tolerate such a drop in standards for surgery, as well as the accompanying explosion of complications resulting from this inadequate training?

And nurse practitioners want to be called doctors sometimes? Without being tethered to doctors? That's another example.

When you go to somebody with a white coat you should know you're seeing a doctor, and not a nurse practitioner or an optometrist. So CMA, with its component county medical societies, is fighting for doctors on scope issues like these.

And, finally, the third big issue—public health and ACA implementation. I'll elaborate more on this subject shortly.

MMS/CMA/AMA serve as physician advocates in the State Legislature and in Congress. What do you see as the most important issues at present?

I like to crunch it down to the Three E's—Economics, Education and Ethnic disparity. We've already talked about economics—Medi-Cal, MICRA, SGR, protecting solo and small group practices, and the availability of doctors, particularly specialists, in rural areas.

Education—measles, for example, and public health generally. These are important issues. We have to make sure our lawmakers know they're getting good information. That applied to the "No on 46" issue, too.

The CMA was eloquent in explaining that MICRA was not just an economic issue, it was about access to care and how without that "more people would die." Some 20,000 Americans die every year from lack of access to care. So when the lawyers said they just wanted to make it fair for people who aren't being compensated enough from their lawsuits, the bottom line was it would have killed more people by limiting access to care for needy patients, because doctors—and ultimately society—would have to pay more to defend against frivolous lawsuits! We always fight when it comes to life.

That is the core of what we do. It is a rationale most groups cannot argue against.

And then there is the issue of ethnic disparity in health care—minority indigent care. Health care disparities hit the bottom of our society. It is intolerable for the most powerful country on earth to have so many people getting inadequate health care. When the Affordable Care Act was passed there were 45 million people who were uninsured. That has decreased by 12 million now. We still have a long way to go, but hopefully we'll chip away at it and make things better. In Marin County alone, 31,000 residents signed up for health care coverage via "Obamacare." That is more than 10% of the people in the wealthiest county in the state! Most of those enrollees applied through the Covered California program.

You've already headed the Marin Medical Society three times. What prompted you to take on this job again? And what issues do you plan to tackle in this fourth term as president?

It's a labor of love! I see the work we do in much the same way I see research. It's important work that benefits the public and allows me to help save more lives than I can touch individually.

My intention is to work to better educate my colleagues about what the CMA does for them. My goals are first, education—spreading the word—and then, following from that, increasing membership and encouraging more active participation by our members.

I told the students this morning that they cannot unbundle health care funding from their future medical practice. I told them their individual efforts will never be able to stop attacks on the medical profession, which won't be good for their careers. But, together, we can accomplish necessary and great things. That's why I'm active in both the county society and the CMA.

You know, it's hard to get people into leadership positions because a lot of them think it seems too self-promotional. But it's not self-promotion. For me, it's an expression of respect for the importance of this profession. And it's volunteering at a level where I can put some of my talents to their best use.

The county societies, CMA and AMA are the comprehensive organizations that encompass the entire medical profession and can actually affect public health and health care policy, which impact millions of people. CMA and the county medical societies—those are the trenches we need to work in if we want to accomplish something for public health, if we want to extend our reach and save more lives than those of the patients we work with in our individual practices.

Dr. Bretan overseeing TB screening for young children in the Philippines. Photo by Lisa Fish.

You plan on running for president of the California Medical Association. What motivates you to do this?

Again, the same thing that pulled me into medicine—saving lives. That motivates everything I do. I just know I can magnify my impact by working through organizations with enormous leverage to improve public health and expand access to care. That's what's behind my work for the county society, my CMA trustee position and my candidacy for president.

What motivates me are the same considerations I just talked about in connection with being president of the Marin Medical Society—helping more physicians understand the importance of what organized medicine does, not only for them but for the broader community in terms of improving access to care and strengthening public health.

That's why I do this, why I'm so active in the Marin Society and CMA. Because this work can help save lives, change the world … and save even more lives. It's a natural progression.

What do you hope to accomplish as president if you are elected?

I want to educate the medical community about the critical nature of CMA's work. I'll work to grow our membership and encourage more members to get active.

I want members to help spread the word further and push hard to make health care work better, not just for practitioners like ourselves, but, more importantly, for our patients and especially for the thousands of people who don't have the kind of easy access to care that everybody reading this interview can just take for granted.

The CMA's House of Delegates and Board of Trustees, of which I'm a member, go through 200-400 resolutions every year and craft policies that are the backbone of what we're going to fight for. Then we take that to the AMA and go through the same process. In fact next month I'll be in California's delegation to the AMA. With our 40,000 members we are the largest state in the most powerful country in the world.

The CMA president is in effect a spokesperson for the practice of medicine in our most populous state, so the presidency presents opportunities to affect

health care policy not just statewide but nationally. It's the president's job to bring passion to the messages our doctors want to deliver. And if passion is a prerequisite for the job, I think I'm pretty well equipped in that area. I'm passionate. I'm committed to this work.

Improving access to medical care saves lives, and the CMA works hard to improve that access. Others might see our efforts to improve reimbursements, for example, as self-serving. But they're missing the point. It's what we absolutely must do to keep our doors open, and open them still wider, for the benefit of the people and communities we serve.

In your last interview with *Marin Medicine,* you said one of the most important aspects of organized medical leadership is "to help fashion rational and sustainable health care policy." Does this mean support for the ACA or, perhaps, amending it in some way?

You know, there are wonderful things about the Affordable Care Act. When we asked CMA members to tell us what they liked about the ACA, the thing they liked best was that it helps those in need. In fact, 38% said they like that it helps those in need and the uninsured, and 25% said they like that it covers pre-existing conditions.

Those are two huge things! Covering pre-existing conditions is critical. It changes the previous model, which was that they'd charge you more or, if you have cancer, you just couldn't get insurance coverage at all. Those are huge benefits, very positive. As for the things that aren't working so well . . . well, I'm an optimist. I don't think you should throw the baby out with the bathwater. You fix those things or you give the baby another bath.

What are the aspects of ACA that need to be fixed?

Well, I already talked about Medi-Cal reimbursement rates, so that's No. 1. Then there's EMR. Why penalize doctors for a system that's not very efficient? Once it's proven that using it is going to benefit your practice, then yes! Make us do it! Because it would be better for the whole medical profession.

> *"CMA and the county medical societies—those are the trenches we need to work in if we want to accomplish something for public health."*

But ACA kind of put the cart before the horse: "We'll punish you if you don't adopt EMR, even though it is an incompatible and inefficient system. We'll wave this carrot momentarily, but then we'll penalize you." These cuts can add up to 15% over the next three years! That almost eclipses SGR. So, yes, we've got to fix that!

There's a bunch of other little things. Prescription drug implementation, a lot of little cuts here and there. But they also add up to about 15%. That's huge! That's another SGR-like pain to deal with. So, yes, that's what the AMA and CMA need to do. We've got to improve ACA.

Another thing. ACA was supposed to bend down the perennially rising cost of health care. We are paying much more in the United States than any other country. We're paying 18% of our gross national product for health care. The next highest is 11-12% in Germany. We could afford to cover everyone in the United States if health care dropped to 13-14% of GNP. We just pay too much for it today. But most of these excessive costs can be recouped if the system is made more efficient.

A lot of those high costs have nothing to do with the doctors. It's hospitals buying new equipment every six months and writing it off. The growth in the cost of medical devices is 17 times higher than overall inflation. ACA was supposed to decrease costs, but they're doing it on the backs of doctors and not where the problems actually reside. The problem is with the hospital corporations, the drug companies—it's on the massive corporate side.

I strongly believe in a patient-centric, physician-led practice. Not hospital-centric, CEO-led. Not insurance-centric, financially led. It has to be doctor-led. We're the ones who know the most efficient ways to deliver care. But they're not cutting the hospitals as much as they've been cutting the docs. We need to change that. The SGR fix to the ACA is going to increase Medicare reimbursement by half a percent every year for the next three years maybe. That's a pittance. The hospitals continue to get 3-5% annual increases. The difference is ludicrous! We need to fix that too.

In your last *Marin Medicine* interview, you said one of your core motivations is to protect the patient-doctor relationship. Protect it from what?

It's being eroded! Remember what I mentioned earlier about something that people might see as "telehealth" but which is really just teleadvertising? Well, that's the nose of the camel that wants to get into the tent. Because there are a lot of large Internet companies out there that would like to be able to advertise and have their doctors—doctors they employ—practice medicine online across the whole country.

That wouldn't be a doctor-patient relationship. The AMA has a long list of requirements for what constitutes a doctor-patient relationship, when it begins and ends. When I talk with a patient, it's just like the two of us talking here. "Hi, I'm Dr. Peter Bretan. So-and-So sent you here because of problem X? I'll examine you, I'll make sure your history is filled out, I might order some tests, and then we'll talk again. I'll tell you what I recommend. Here are the risks, the complications and the alternatives." And it's still a doctor-patient relationship when a portion of our interaction is done electronically in ways that allow me to serve a wide rural area efficiently.

For there to be a doctor-patient relationship you can't be anywhere in the world or cyberspace. You have to be licensed in the state where you are seeing the patient. That enables patients to

have their rights protected and know who is responsible, who is legally liable for their care.

California is the toughest state in the country to get a medical license. It's certainly one of the toughest states to get into medical school, and because of this we have the best doctors here. I don't think the state Medical Board or the hospitals here are going to want to let people with a national license practice here without a say, because we have established standards for the doctor-patient relationship, backed by a strong peer-review system for medical liability.

That is what I mean by protecting the doctor-patient relationship in the Internet age. Because no matter what happens, the practice of medicine must still be between the doctor and the patient. And if the patient wants to go see another doctor, then I hand off the baton and send over the medical records.

Ask any three people why medical care is so expensive in the U.S., when it's free to patients—although probably not to society—in so many other developed nations, and you'll probably get three different answers. If you exclude the fact that in the U.S. insurers and patients pay for it, while in Europe, for example, government generally does, is U.S. medical care really more expensive, or not?

There is no such thing as free. So when you say "free," when looking at England's health care, for example, they're paying for it with a national health tax of 17.5%. So your question repeats a common misconception about U.S. health care. But that does not mean we can't do much better.

The bottom line is that we have to be more efficient in covering everybody. You know, Germany has their system. It's called Bismarck, and France followed it, Taiwan followed it. And it's a very good multipayer insurance system, but heavily regulated with a common, nationally set payment fee schedule. Then there's complete socialized medicine, which is what England has—paid for with taxes that would not be tolerated in the U.S. Then there's a Medicare-type system, which is what Canada has. And finally there's out-of-pocket, which is the most inefficient in terms of health care disparities.

What kind of system do you think we will ultimately have in this country?

Actually, I posed that question to AMA President Robert Wah. "What do you think we are ultimately going to do? Are we going to go Bismarck? Will we have a system like England's?" He said, "No, I think we'll have a uniquely American system."

I agree with him. I'm an optimist. We have very bright, entrepreneurial people here, and we have a lot of immigrants. There's something different about immigrants. My parents were immigrants. California is the 49er state. People were brought here by the Gold Rush and more recently by Silicon Valley. This country won World War II thanks to the strength and ingenuity of our industry—for instance being able to manufacture a Liberty Ship in just a few days, right here on Mare Island where Touro Medical School is located today.

So like Robert Wah, I think we will have a uniquely American system and that it will rely on our technology. Look what Google has done, look at Facebook, look at Silicon Valley. That's where we are incredibly powerful. And we're on the cusp of even greater things.

When Genentech found a way to mass-produce certain clones—to mass produce specific proteins across the board now—they exploded a whole industry. I have no doubt that's where we're heading. These things just keep progressing.

We haven't paid enough attention to health care delivery. We've been looking at the cost side, the back end, the reimbursement side. Robert Wah thinks we need to pay attention to the delivery of health care up front. I'm already doing that with telemedicine. Not everybody is an early adopter. But they're going to embrace telemedicine sooner or later. I think the efficiencies it makes possible will bring costs down.

We're not always going to be delivering care the same way we are now! It'll be much better! We don't talk on phones the same way we used to. We don't pay our bills the same way. We don't bank the same way. We don't live the same way we did 10 years ago, and we're not going to be living this way 10 years from now. And hopefully health care will benefit. But it will have to change dramatically.

We have to foster technology that enables us to deliver health care more efficiently and less expensively. Then we'll catch up with the rest of the industrial world in terms of health care delivery. But it won't be a German system, it won't be Canadian, it won't be English. It will be uniquely American.

Again, doctors are going to have to keep up with technology, keep up with health care policymaking. You've got to be an economist and a techie as well as a physician. Not all of us, maybe, but more of us. Hopefully we'll educate enough tech-savvy, economic-policy-savvy doctors so that we can craft rational, sustainable health care policy. ◇

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Marin Ranked State's Healthiest County

Matt Willis, MD, MPH

For the sixth year in a row, the Robert Wood Johnson Foundation, in collaboration with the University of Wisconsin Population Health Institute, has ranked Marin as California's healthiest county in its annual County Health Rankings, which assess counties across the entire nation. The rankings are based on data collected from 2004 through 2013.

The foundation's rankings consider multiple factors that affect people's health within four broad categories: healthy behavior, clinical care, physical environment, and social and economic factors. The rankings account for a range of factors that, when improved, help make communities healthier.

Marin ranked highest among California counties (56 of the state's 58 counties were included in the rankings) in several areas, including clinical care, healthy behaviors, length of life and lowest teen birth rate. We ranked in the top 5% of California counties in, among other categories, low premature death rate, low prevalence of adult obesity, low rate of physical inactivity, and a high per capita rate of primary care physicians, dentists and mental health providers.

Dr. Willis is Marin County's public health officer.

However, the rankings are based on population averages and mask important areas of unmet need. While Marin residents—and physicians in particular—have good reason to be proud of our status as California's healthiest county, it is important to recognize that not everyone in Marin enjoys high levels of health and wealth. The income gap can make poor people more vulnerable to poor health.

Challenges We Face

Income inequality. Marin ranks poorly—in the bottom half of California's counties—in income inequality. There is a wider gap between the rich and poor here than in many other counties. Our high cost of living and insufficient affordable housing cause many poorer residents to be segregated by neighborhoods and schools, breaking down social connections and creating stress. This income gap and related stressors can lead to poor health outcomes for residents who struggle to meet basic needs.

Increasing opportunities for educational achievement, safe housing and self-sufficiency can help give everyone a chance to live a healthier life. High-quality childcare and preschool for all children will help them get ready for kindergarten, a key predictor of academic success and, later, economic success. Affordable rental housing and programs that help lower-income and middle-class families achieve home ownership are also an important step in building intergenerational wealth. Increasing the minimum wage locally can also help working families and strengthen the economy.

Several regional and local initiatives such as Rise Together, Marin Promise and Marin Strong Start are working on alleviating poverty and setting the foundation for future success for all Marin residents.

Alcohol and prescription drugs. Marin continues to fare poorly—again in the bottom half of the state's counties—in both alcohol- and drug-related metrics: excessive drinking, driving deaths related to alcohol, and deaths related to drug poisoning. For five years in a row, more than one-fourth of Marin adults report binge drinking.

Growing concerns about these issues have led to widespread community action. Coalitions in Mill Valley, Twin Cities, West Marin and Novato are all working on community-based solutions that (1) revolve around better enforcement of laws known to reduce drinking and (2) promote a culture where alcohol abuse is not the norm. For more information contact klaw@marincounty.org.

Launched in 2013, RxSafe Marin is a coalition of community members and experts collaborating to tackle the local prescription-drug-misuse-and-abuse epidemic. Strategies include working with prescribers toward more judicious prescription practices, promoting safe medication storage in homes, and

How does **Marin** compare
to the other 56 counties ranked in California?

HIGH
- **food environment index***
- primary care physicians per capita
- mental health providers per capita
- dentists per capita

LOW
- premature death rate
- prevalence of adult obesity
- rate of physical inactivity
- **teen birth rate***
- **percent of uninsured adults***
- **percent unemployment***
- violent crime rate
- percent of children in poverty

TOP 5%

***No. 1 in the state**

TOP 10%

HIGH
- percent with some college
- percent of high school graduation

LOW
- rate of preventable hospital stays
- average number of mentally unhealthy days[1]
- percent of adults reporting fair or poor health (age-adjusted)[1]

TOP 25%

LOW
- number of physically unhealthy days[1]
- levels of sexually transmitted infections

HIGH
- access to exercise opportunities
- levels of mammography screening for Medicare enrollees

- **Excessive drinking[1]**
- **Alcohol-impaired driving rate**
- **Drug-poisoning mortality rate[2]**
- **Percent of workers driving alone with a long commute**
- **Income inequality**

BOTTOM 50%

TOP 15%

LOW
- percent of adults who smoke[1]
- percent of children in single-parent households
- average daily air pollution
- percent driving alone to work

LOW
- **rate of low-birth-weight infants**
- **injury mortality rate**
- **exposure to drinking water violations**
- **rate of housing problems**

HIGH
- **level of diabetic monitoring of Medicare enrollees**
- **level of social association**

TOP 25–50%

1 Data collected from Behavioral Risk Factor Surveillance System 2006-2012 (2005-2010 for social support indicator) and may vary from other local sources used in county health reports and fact sheets.

2 Drug poisoning deaths was an additional measure and did not contribute to the overall county health rankings.

Marin Health & Human Services, 2015

creating more medication take-back sites. To learn more, contact RxSafeMarin@gmail.com.

An aging population. Good health and long life expectancy mean that Marin has a growing number of aging residents. In 2023, an estimated one in four Marin residents will be 65 and older, compared to one in five today. Fortunately, the Marin County Health and Human Services Aging and Adult Services program, along with many community partners, is poised to act and serve as an advocate for the needs of our seniors. Our active Commission on Aging advises the Marin County board of supervisors and holds monthly public meetings. The county's Health and Human Services information and assistance line, 415-457-INFO (4636), can help older adults and their caregivers find the services and support they need.

As Marin's public health officer, I hope to spread the standard of clinical excellence modeled by our county's providers into all areas of public health, to support community wellness for everyone in Marin.

This Public Health Update is intended to provide information on key local public health topics, especially those that may affect clinical care, and to strengthen communication between my office and the county's physicians. I welcome suggestions for topics to address in future issues of *Marin Medicine* that will help support our county's physicians in their efforts to provide outstanding health care. ◇

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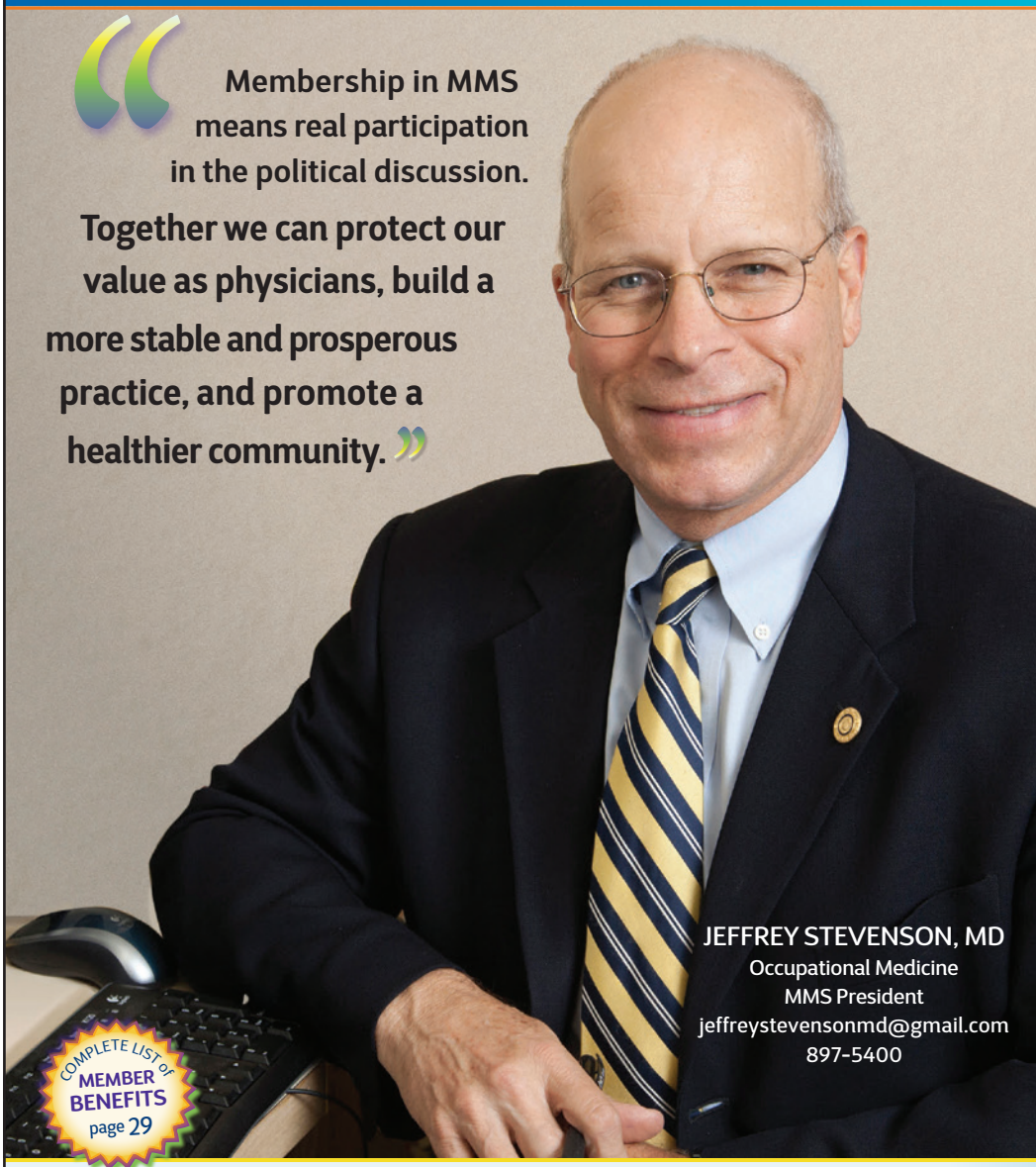
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We've Come a Long Way and Are Still Making Progress

Mitesh Popat, MD, MPH

MCC in Novato: one of four medical clinic locations.

Marin Community Clinics is the county's largest safety net provider of medical and dental care to low-income populations. Our mission is "to improve the health of our patients and community by providing high-quality, cost-effective, culturally sensitive care, patient-centered care."

When we began offering services 43 years ago, Marin Community Clinics provided very basic medical care to the underserved in church basements in Fairfax and Mill Valley. Everyone did their best with limited resources, and a small number of Marin physicians and nurses generously volunteered their time.

The Clinics have come a long way since then. Today, our not-for-profit organization is not only serving more people with sophisticated medical and dental care, but also playing a vital role in health care reform by providing affordable, accessible care. We have truly come of age.

Dr. Popat is the chief medical officer of Marin Community Clinics.

A quick snapshot of where the Clinics stand today:

Marin Community Clinics is one of only 1,200 Federally Qualified Health Centers in the U.S.; this designation allows us to receive federal funding and enhanced reimbursement.

We now serve 35,000 individuals a year—13.5% of Marin's population. Half of our patients are children. The people we serve come from all walks of life and include individuals on MediCal, Medicare, Covered California and private insurance.

Our organization operates four medical clinics (two in San Rafael, one in Novato and one in Larkspur), three dental clinics (two in San Rafael and one in Novato) and two teen clinics (one in San Rafael and another in Novato).

We have 240 staff members, including 40 medical clinicians and 18 dentists.

Our annual budget is $30 million.

Our success is due in great part to strong collaboration with others, including physicians and other clinicians, the County of Marin, Marin General Hospital, Novato Community Hospital, Kaiser Permanente and Operation Access.

We benefit from strong philanthropic support; in the past 15 years alone, we have raised $22 million from generous community donors.

In addition to primary care for adults and children, we provide the following medical and ancillary services:

- obstetrics and women's health
- optometry
- physical therapy
- on-site labs
- on-site pharmacies

The addition of dental services six years ago was a major development. Today, under the leadership of Chief Dental Officer Connie Kadera, DDS, we

Clinic staff performs well-baby visit. Photo by Tim Porter.

have 19 dental chairs and operate seven days a week, serving 11,000 patients a year.

Our facilities are modern and outfitted with the latest in technology. Since 2012, all our documentation is done in electronic health records.

New developments

With the advent of health care reform and the expansion of Medi-Cal eligibility criteria, we are seeing tremendous growth in our patient population for virtually all services. (From 2013 to 2014, we saw a 10% increase in the number of individuals served.)

Consistent with our mission, we are continually looking at how we can meet this increased need.

This past year, we expanded clinic days and hours to meet patient demand; most of our sites are now open evenings. In addition, we are planning to expand our Novato site, where we have purchased the existing clinic buildings and will be converting more square footage to clinical care usage. Soon, we will add x-ray services at our San Rafael Clinic. Having on-site radiology will not only be more convenient for our patients—many of whom lack transportation—but will make for more efficient, effective and timely communication among our provider team. We are building on past success with our on-site pharmacies—and the dividends that improved coordination has created.

Patient-Centered Health Home approach

In December 2014, the National Committee for Quality Assurance gave the Clinics its highest rating (Level III) for our achievements in implementing the Patient-Centered Health Home model.

This model of care, which emphasizes the partnership between provider and patient, has proven particularly effective with our patient population. Specifically, we assign patients a primary care provider. We have created stable "teamlets"—provider and medical assistant. We have integrated our nurses into our call center as well as the "pods" where our providers and medical assistants are based. The goal is to provide genuine team-based care, where a single visit may involve different members of the patient's care team and allow expanded medical case management, as well as health education for chronic diseases.

We have also expanded other services, including behavioral health, composed of licensed clinical social workers (LCSWs), psychiatrists and psychiatric nurse practitioners. Their integration into the care team helps us meet our patients' psycho-social needs. We have expanded chiropractic services and group medical visits for diabetes, and we have added a registered dietician to provide greater nutrition expertise.

We have also deepened our quality improvement efforts. We are currently working with the American Cancer Society to improve our patient outreach efforts around colon, breast and cervical cancer screening. We also work closely with our managed medical plan,

Partnership Healthplan; last year, we obtained an all-time high in quality incentive payments for our excellence in a wide range of clinical measures, from diabetes care to childhood vaccination to cancer screening.

Our patient satisfaction rates demonstrate our overall effectiveness, with 98% of our patients saying that they would recommend the Clinics to others.

Wellness and prevention focus

We are increasing our investment in wellness and prevention, working hard to promote healthy diet, regular exercise and early screenings so that our patients can live longer, healthier lives.

I went into primary care to tackle the upstream causes of disease. End-stage renal disease results from chronic diabetes, chronic obstructive pulmonary disease (COPD) results from a lifetime of smoking, and stroke results from uncontrolled high blood pressure. All can have different outcomes. Many of the issues that lead to these conditions are rooted in socioeconomics and social stress, and it should be our imperative to tackle them. Based on the Portrait of Marin 2012 [1], we know that there is a 13-year life expectancy gap among towns in Marin. As a community, we can work to reduce this disparity.

One example of our efforts to try to change health behaviors is our Community Health Hubs. They are held weekly at both our San Rafael and Novato sites in partnership with LIFT-Levantate and the food banks. Free nutritious food is provided, along with chronic disease screenings, health education and exercise demonstrations. Each week, we serve hundreds of individuals who might not otherwise have access to these services.

This community-based, family-oriented activity brings multiple wellness and prevention activities together under one roof. Healthy nutrition and education about food choices and preparation has to be at the base of the pyramid of health. This is, of course, not to mention the social stress that patients experience from food insecurity and the bearing that has on individual health. Hopefully, as a system, we can work to reduce health disparities.

Diabetes program

We have also expanded our Diabetes Program. Health screenings are conducted at the Health Hubs mentioned above. If an individual is found to be diabetic, pre-diabetic, or hypertensive, they are referred to the clinic to see a medical provider.

From there, the provider may refer the patient to a series of group medical visits, where education is provided about his/her medical condition, along with screenings for concomitant depression, as well as stretching and relaxation exercises. All this is done while following the tenets of motivational interviewing—which has the clinician meeting patients "where they are." The basic concept is to make small, achievable changes and build on successes from there.

The goal is to help people manage and take ownership of their illness, while not being defined by it. In chronic disease management, having the understanding and confidence to be in control of one's own illness—as opposed to being a victim of, or suffering from it—is key to preventing the downstream consequences.

How the Clinics provide specialty care

As a family practice physician, I know my patients can often benefit from seeing clinicians with expertise in a specialty area of medicine, for example orthopedists, gastroenterologists, urologists and cardiologists.

In the past, we relied on a small number of local physician specialists who generously donated their time. Today, a small group of physicians and other specialists continue to volunteer. Their commitment to our Clinics and our patients is truly amazing, and they make a tremendous difference in our patients' lives.

We are now large enough that, in addition to using volunteers, we have begun to hire our own specialists. Currently, we have staff clinicians in the

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When a patient needs care that we don't provide, our Referral Department works to find an appropriate clinician who will accept the patient's insurance or see them on a sliding fee scale. Our team makes about 1,200 referrals a month. Referrals for hernias, endoscopies, urologic procedures, cyst removals and biopsies are among the most common. For uninsured adults, Operation Access facilitates free outpatient procedures, and Kaiser Permanente conducts some evaluations and outpatient procedures.

Challenges remain, however. It is sometimes difficult to find a local expert able to see some of our patients. This results in either delays in care, sending the patient out of county for care, or rarely (thankfully) no care at all.

Hiring our own specialists is making a big difference, but we are just getting started. We continue to need specialists, either voluntary or paid.

I invite any interested individuals to contact me at the email address below. We hope you will help us create a bright, healthy and more equitable future for all Marin residents.

For more information, visit www.marinclinics.org. ◇

Email: mpopat@marinclinic.org

Reference

1. www.measureofamerica.org/marin

NEW MEMBERS

Adrianna Browne, MD, Dermatology*, 535 Miller Ave., Mill Valley, 94941, Johns Hopkins Univ 2007

Julia Haimowitz, MD, Dermatology*, 99 Montecillo Rd., San Rafael, 94903, Harvard Med Sch 1993

Il-Ran Hwang, MD, Internal Medicine*, 3900 Lakeville Hwy, Petaluma 94954, Yansei Med Sch 1989

Hong Ren, MD, Internal Medicine*, 3900 Lakeville Hwy, Petaluma 94954, Taishan Med Coll 1991

* = board certified

Eulogy for Elliott

Ann Troy, MD

After reading "Here Come the Dogs," by Irina deFischer, MD, in the Winter 2015 issue of Marin Medicine, *Dr. Troy emailed us her "Eulogy to Elliott," written in 2007. We felt it merited sharing with Marin's entire medical community.*

Elliott was, to put it simply, the world's most wonderful dog. He was evaluated as a puppy by Canine Companions for Independence, who wanted to use him as a breeder. Somehow, he got neutered by mistake and they were devastated: "This is the best dog we have ever seen!" He could also have been a magnificent show dog—except that he had a 1-cm scar on his nose.

Their loss was my gain. This gorgeous golden retriever was given to me, by his breeder, when he was six years old—the most wonderful gift I have ever received.

Thus, he began a new career as a physician's assistant in a pediatric office. He was there to warmly welcome and reassure patients and their parents, to distract and comfort a frightened child, to cuddle up with while having a breathing treatment or waiting for lab results, and to make us all laugh and smile. There were occasional photographic emergencies, when I ran from the exam room to get my camera and take a picture of a patient with Elliott! At the next visit, the patient would be given the photo to treasure forever.

Dr. Troy with Elliott. **Photo by Luanne Greco.**

Elliott was so gentle, I could trust him with a two-week-old baby and, somehow, their mothers knew it too. Once, he was standing in my waiting room with his mouth open, and a little boy who had just learned to walk waddled up to him and stuck his hand and a biscuit into Elliott's mouth. Much to our stunned amazement, Elliott just stood there, perfectly still! This little boy's mother used to be afraid of dogs and had let out a yelp the first time she saw him. She quickly fell in love with him and gave him a hug whenever she came. Many people overcame their fear of dogs with Elliott. Fear turned to love.

There were patients who might, otherwise, be reluctant to see a doctor who would happily agree to come to my office because they knew he'd be there. There were even patients who would pretend to be sick so they could come see Elliott! The many drawings of him on my waiting room walls are testimony to how important he was and how much he was loved.

Elliott was beautiful and he knew it. He heard that word so often that he responded to it as he would his name. Once I entered an exam room and exclaimed to a four year old, "You are so beautiful!" and Elliott came bounding in, much to everyone's delight!

I never had to worry about Elliott being lonely. If I tied him up outside a shop, there was *always* a throng of people petting him and telling him how beautiful he was. When we walked, he would not let me walk past anyone who could pet him—and, almost always, people wanted to.

He was the most wonderful dog anyone could have. He never hurt any of the treasures in my house, he never dug in the garden, he always pooped where I wanted him to, he was good in the car, and he never barked. He was always, loyally, at my side. He was the most patient, loving and gentle being I have ever known.

Elliott died, peacefully, in my arms on September 10, 2007, after almost 13 years of living and loving life fully. He will be sorely missed—and loved forever. ◇

After being in solo practice for 14 years in Terra Linda, with her canine physician's assistants, Dr. Troy is joining Dr. Michael Yamaguchi at Terra Linda Pediatrics.

Email: anntroy@sonic.net

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A Talk with
Robert M. Wah, MD, AMA President

Doctor Wah, a reproductive endocrinologist and OG-GYN in McLean, VA, is the 169th president of the American Medical Association. He will speak about the AMA's leadership in health care reform and the challenges facing physicians in 2015 and beyond, including how health information technology will deliver better information for better decisions.

Thursday, July 9, 2015

Reception: 6:00 p.m. • **Dinner and Program:** 6:30 p.m.
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Medical Society Members & Spouses/Guests: No Charge
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TO REGISTER:

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Email: Send message to Dennis Scott at dscott@accma.org (include your name, spouse/guest, etc.)

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